the patient, for this may be a source of discouragement to him. Here no general rule can be given, and the therapist must gauge how much the patient can receive and still retain a positive attitude to the plan.

Another problem in the planning is that of the respective amounts of definiteness and of plasticity in the plan, for one might err in both directions. We would advise, therefore, that it be made as definite as possible, because of the dynamic and the suggestive or creative effect of a clear picture; but be just as ready to modify it at any time, and even repeatedly, if some good and sufficient reason arises. Also the plan itself should be dynamic or, to put it another way, the therapist should have a definite picture of the goal, but also the partial plans of the various intermediary steps from the starting point to the achieving of the goal; and these can be plastic and modified according to new elements of judgment arising out of the dynamics of the treatment itself.

TECHNIQUE OF IDEAL MODELS

Purpose

The purpose is clear: that of utilizing the plastic, creative, dynamic power of images, particularly of visual images, which we examined in dealing with visualization. Here we emphasize the creative aspect of imagination in the sense that imagination creates mentally and emotionally, and then that which has been imagined and visualized is expressed outwardly through the use of natural means.

In therapy it is a process of substituting a realistic, attainable model for those already existing in the subject which do not have such qualities. We must become aware that each of us has within himself various self-models or models of the ego, or—more exactly, using our terminology—of the personality. Such models are not only diverse in nature, origin and vividness but they are in constant conflict between themselves, and this constitutes not only one of the major difficulties but is also one of the most useful fields of application of a right psychoanalysis. This awareness of the self-models is one of the purposes of psychoanalysis which we will touch upon in 'Combination with Other Techniques.'

Before dealing with the ideal model—of that which one can become—which is the true goal of this technique, we could classify

in the following way the multiplicity of models which prevent or obscure our self-recognition of what we actually are at present:

1. What we *believe* we are. These models can be divided into two classes: those in which we over-evaluate ourselves, and those in which we under-evaluate ourselves.
2. What we *should like* to be. Here come all the idealized, unattainable models very well described by Karen Horney.
3. What we *should like to appear* to be to others. There are different models for each of our important interpersonal relationships.

This would seem at first appearance to exhaust the categories of models, but there are three other classes which are important and sometimes overpowering:

4. The models or the images that *others project on us;* that is, the models of what others believe us to be.
5. Images or models that others make of what they *would like us to be.*
6. Images which others *evoke and produce in us;* i.e., images of ourselves evoked by others.

We will clarify the last point because it is more obscure. The fourth and fifth classes are those of models which are projected on us but which we recognize as of "foreign" origin, so to speak, and which we do not accept and sometimes bitterly resent. Instead, those of the sixth class are the models which others succeed in making us accept, and therefore can be the most harmful.

7. There is finally the model of that which *we can become.* This constitutes the goal of the technique.

Before working with the patient on an ideal model, what we need to do first is to make the patient aware of all these models, which may be conflicting and some of which are largely unconscious. This brings in one of the deeper aspects of analysis; not so much to look for small traumas or small incidents of the past, but for the *dramatic, analytic situation of the present.* It is the present, existential situation of the patient, who—having these conflicting sub-personalities, models and ideals in himself—is at a loss how to deal with them. Some psychologists have called these models "self-images" or "self-concepts," but we suggest that a consid-

eration of the various existing and conflicting models can be a rich and extremely valuable part of analytical work.

Rationale

The main point behind the rationale was mentioned in our discussion of the Technique for the Training and the Use of the Imagination, i.e., the utilization or taking advantage of the psychological law that every image has a motor-element which tends to be translated into action—which is a rather dry, objective way of indicating the creative power of imagination. This law was formulated by a pioneer of modern psychology, Théodule Ribot, in the first years of this century. The model must first be static and then "manifesting in motion." The stages are: first the *idea*, which if seen as desirable becomes an *ideal*, and when ardently sought after emerges or expresses itself in form and function. This definition, fully understood, removes the semantic confusion which has arisen in regard to the words "ideal" and "idealized." The frequent wrong connotation, of impracticality or unreality, should not deter the use of the designation "ideal" in speaking of the ideal model.

These stages of idea-ideal-form-function can be correlated with or are analogous to scientific or industrial blueprints preceding the manufacture of functioning models; or in some degree to gestalt field theories.

Procedure

There is no one "ideal model" but several, with diverse indications, as will be seen by their description. There is one which is being used unconsciously by most people all the time, that of an *external or indirect model.* This is the unconscious or conscious imitation of a human model, one who represents what is considered as desirable or who arouses admiration or represents an ideal. This falls within what is usually called "hero worship," because worship or admiration spontaneously and naturally evokes the urge to imitation. On the value and effectiveness of this technique Thomas Carlyle eloquently expressed himself in his well-known book *On Heroes and Hero-Worship.* Also we have Plutarch's *Lives*, which is a collection of hero-images, and *Representative Men* by Ralph Waldo Emerson. Hero worship which

was much practiced in the past has, most unfortunately, been substituted in modern times by "idol-worship"—and by "idols" we designate those inferior models represented by some movie stars, sports and TV prize winners, successful businessmen irrespective of their character or moral stature, etc. Sometimes the external model chosen is a less ambitious and unrealistic person, some particular one whom we admire and who therefore creates a pattern to which we tend to conform. Perhaps such cases were more frequent in the past than the present: a person of one's own family—father, mother, or some other closely related adult; not infrequently one's teacher. In therapy the influence of the therapist, as a dynamic ideal model, can be used both constructively and destructively in the therapeutic relationship.

In utilizing this technique the first requirement is to discard unrealistic and unworthy models. But even when a model held by a patient is a good and helpful one, there are two pitfalls to be avoided in order that its influence may be really constructive. There should not be a passive or too close an imitation, because no one should become wholly like another. Some of the outstanding qualities of the model can be introjected, but not the whole of the personality characteristics.

The second danger to be avoided is a personal attachment to the human representative of the model. The model should be a model and not the living person. It should be an idea, an image, introjected, and not a personal attachment to the inspirer of the model. Often, at first, the two are connected, and rightly so. But gradually the process of introjection or subjectivation should take place, in order to dissolve the affective bond with the model-inspirer and to have the model become a dynamic, inner creative pattern.

How from a practical angle do we help the patient to discard an unrealistic or unworthy model?

The first step—which one could call the aggressive approach—is that of debunking the unworthy model: to show the reality behind the attractive mask, e.g., of a glamorous movie star, by showing all the human frailties of such a model-inspirer, drawing on biographical data to reveal the unhappiness and frustration of such a person. The same can be done for what has

been called the "ideal of the animal man," i.e., the man wholly identified with his physical body, and only with that.

The therapist must not be afraid of a direct intervention and debunking of such idols, especially in this analytical or destructive stage of the treatment which is not directed to influencing the patient *towards* something, but to freeing him from hindrances to becoming his better self, his true self—this is an important point. We must be very cautious not to influence a patient according to our own ideal, of ourselves or of him; but every active, even aggressive, help in freeing him from limitation and the many kinds of images which keep him in bondage is of value.

The debunking of the "Hollywood-star-ideal" for instance—showing the hard facts behind the facade, through objective biographical details—is in no way a counselling. It is an active intervention by the therapist, not a counselling in the strict sense of the word, because it does not indicate in what direction the patient should now go, but shows him what are impossible or dangerous by-paths into which he could be induced to go.

We now come to the wholly conscious and direct use of the technique of the ideal model, that is, of the patient *visualizing himself* as possessing the qualities which it is good or necessary to develop and to build into himself. This is a very well defined model. It is not a general model of perfection, of complete psychosynthesis, but the model which represents the next and most urgent step or stage—that of developing an undeveloped psychological function, focussing on a single specified quality or small group of qualities, or abilities which the patient most needs in order to achieve, and even to proceed with, his psychosynthesis. He is asked to visualize himself in possession of that particular quality or actively using that particular psychological function. The visualization should be as vivid and "alive" as possible. The patient is taught and trained to see himself in a definite situation in which he wills to express and to put into action the needed quality.

With the help of the therapist, a form of dramatization can be developed, in which the subject sees himself in action and playing several roles. For example: each role implies personal relationships; therefore we can suggest to the patient that he visualize a scene fitting for each of the roles, functions or sub-

personalities; e.g., a scene in which the subject plays successfully and satisfactorily the role of son or husband, of father or a professional or social role, etc. In playing a particular role the subject, by just imagining that he is playing it successfully, brings into action qualities which up till then had not been sufficiently developed. This, in effect, becomes a psychodrama-play-technique *in imagination,* and if well performed it has many, if not all, the advantages of actual psychodrama without its practical difficulties of execution.

Since, for many practical and therapeutic reasons, there is a choice of functions or qualities that we may select for development in each phase of the therapy, *how do we help the patient choose a particular function or quality upon which to concentrate?* This is a practical question. It is related to the stage of planning which we discussed previously. In the planning, both therapist and patient agree which part of the program to take up first, and this includes the choice of the functions or qualities to be developed through this technique of model-building and acting.

How is the technique presented to the patient? As simply as possible, for almost all are able to understand if it is presented in clear simple terms. We first tell him of the goal and the rationale of the technique. We assure him that it is very effective if practiced well, and then with him we build up the blueprint, the model. Frequently it is a collaboration, in which the therapist tentatively presents the outline of the model and asks if it is acceptable; or he suggests to the patient that he can modify it, and especially that he complete it more "concretely." The therapist then gives his approval and the patient starts in the same session to build a model with the active help of the therapist, who assures the patient that he too is building the same model with and for him. As we previously said, this active cooperation is encouraging, suggestive if not actually influencing.

As a practical procedure, it is generally preferable to carry out this technique with the eyes closed. We also favor that the patient be sitting, not lying down, since this is not an analytic technique to bring forth unconscious elements, but rather a conscious technique of building that which one has decided is advisable to build—with the "I" or self in control. In general, we limit the couch to analytical procedures and to relaxation exer-

cises; and all the rest of the treatment is made with the patient sitting more or less in front of, or sideways to, the therapist, which gives a more normal situation for interpersonal relationships and favors a quick interchange between patient and therapist—also, it has the advantage of eliminating all passive half-dreaming attitudes and reminds the patient that what is required of him is the action of his conscious self using his will.

Regarding the time to be given to this exercise in a session, it depends on the patient's ability for persistent concentration. In general we put the emphasis on the vividness and intensity of the visual evocation and not on its prolongation—because a very vivid image can have an instantaneous effect; just as a photograph taken in bright sunlight immediately impresses the film, so a very vivid image immediately imprints the plastic aspect of the unconscious. It is a vivid, short, repeated evocation; and it is useful to repeat it over and over again. By "repeat" we mean that we ask the patient to do this himself at least once every day, and also a few times in each session. As to how long this process needs to be continued—realizing, of course, that much depends on individual cases—we could say that the evocation of some form of ideal model should go on during the whole of one's life, changing the model periodically in order to develop successively various needed functions.

How is the desired model worked through into action? In other words, how do we help the patient translate images into concrete reality, or how can we help the patient to translate the desired good into actual altered behavior?

The first step requires the active will of the patient, encouraged by the therapist. The therapist can say: "Now you see that in imagination you can perform the role, be the model, quite easily, without those disturbing emotional and psychosomatic reactions. That shows that the ground is free. Now go ahead—live and relive it in imagination and then seek to play it in reality; you can go ahead with a good prospect of success." Sometimes we add "What can further help you is not to care so much about the results. Just try, make the experiment in a detached attitude. If you do not succeed this time, you will succeed the next." This experimenting can also be modified; for instance, if the patient is a performer, a musician, we can say "Just try to give your performance before a small group of friends and see what happens; and then, if you find out that it is possible to do this, then repeat the performance before a larger public." In short, the translation process is this: an active will, an experimental detached attitude and, if possible, a playful attitude, so that the subject can always focus his greatest interest on the experiment itself and not on the practical results. This latter point can be a great help.

At a somewhat advanced stage of the treatment we suggest a further use of the technique, i.e., that of a *general model,* a model of the whole new psychosynthesized personality. That, of course, requires much previous training and, being more complex, demands a little longer time for each visualization. The patient is asked to visualize himself as the new, whole-functioning, self-actualized being with the aim and the reward of completed (always in a relative sense) psychosynthesis. This includes the subject feeling himself integrated, freed from both his symptoms and his outstanding deficiencies, harmonized with the various functions, the various roles he has to play, not conflicting but cooperating in a many-sided, rich life.

This is a general model, the general pattern of a self-actualized individual. Each patient in cooperation with the therapist can make it more definite within, of course, the limits of his empirical possibilities.

Indications and Applications

These are very extensive. In all walks of life one sees the importance, even the need, of clear planning, preparing exact blueprints and even scale models of what one wants to create or build. There is exactly the same need in psychological and psychosynthetic purposes, and the same general procedure can and should be extensively used. Here, too, clear planning and a definite pattern are among the chief elements of success. Therefore all the required time, attention and concentration should be dedicated to this essential and often neglected phase of therapy and psychosynthesis, of education and self-realization.

In other words, this technique is indicated practically for every psychosynthesis and for all patients, because it is a necessary stage in all psychotherapeutic procedures.

Limitations and Contra-Indications

In apparent contrast to the "universal" indications just mentioned there is one important contra-indication of this technique. It is not really a contra-indication, in the sense of not using it at all, but in the sense of using it only after or at the final stage of another technique. These specific cases—quite frequent—are those in which there are present in the subject, more or less consciously, drives or attitudes which are in direct contrast to the model or pattern to be visualized and then realized. When there is this counter-current, so to speak, it would be a mistake to try to force upon a patient, to superimpose as it were, the ideal model or pattern. The result would be either a repression in the unconscious, with the well-known harmful effects, or the arousing of an active opposition which would forfeit or make difficult the success of the technique we are considering.

To give specific examples: when the subject has an intense fear or even a phobia of performing a certain action, or he takes a certain set attitude under certain circumstances. For instance, a student before an examination, an actor or a singer before a public performance, an employee before an interview with his boss. In all these cases where the emotion is intense it would not be possible to visualize over and over again perfect behavior in the given situation, repressing the fear or anxiety. The same can be said in visualizing an ideal of loving behavior towards some individual or group when there are in the subject strong hostile or aggressive drives against the same people. In these cases the technique would be preceded by the use of another one which has also great value in itself. This is the technique of imaginative training and desensitization described on pp. 226–28.

In other words, what one needs to do first, is to have the patient imagine, visualize himself, with some of his defects and undesirable traits, in the situation which is feared or avoided; this is needed to bring forth to consciousness those elements which should be worked through before the more desirable pattern is introduced and reinforced. To be more precise, the patient has to visualize himself in the given situation and then if, spontaneously, emotions of fear or anger come up, the patient tries not to fight them. This is the point: *not to fight them* but to be permissive, to

accept and to experience them. And this has to be done over and over again for a sufficient number of times, for in doing this there is a spontaneous—not forced—freeing of what could be called "psychological allergy," and after a sufficient number of times the patient without any effort finds himself free from the negative emotions. Then he is in a position to perform effectively the technique of the ideal model.

This confirms one of the essential procedures of general psychosynthesis; that is, a right succession and combination of all that is best of psychoanalytical procedure and the best of the active techniques. Up to now, untortunately, in most cases they have been adapted separately.

The above is an example of how an active Technique of Imagination and Visualization can be used for analytical purposes to bring forth into consciousness elements which heretofore were not fully accepted by the individual and therefore partly repressed.

The technique of visualization first serves as a discovery of these drives and tendencies, then as a catharsis or elimination, and thirdly as the active development of the opposite positive trends.

If we started with only the positive trend we would not really deal therapeutically with the situation. This explains the chief deficiency in emphasizing only the positive, forgetting and neglecting the negative aspects of human nature. This partially justifies the hostilities in certain circles against the more superficial optimistic advice given for peace of mind and so on.

The important point is that we need to deal in imagination with the negative aspects of the individual before we can fully impress the progressive desired good, although the desired good may be in mind before the negative aspects are brought up into consciousness. This brings to mind the difficulty that is often experienced with many patients when we ask them to visualize themselves having positive or so-called "constructive qualities." One part of them—the better part, so to speak—would like to acquire the good or at least express it more fully, but after doing this exercise of the ideal model once or twice they give it up. When this happens, it indicates that there are certain forces in the individual which run counter to the constructive tendencies, and these resistances need to be dealt with.

Combination with Other Techniques

A special combination is that with planning, because a concrete plan, not abstract general planning, implies a clear visual pattern of the end to be achieved. The other special combination, that just mentioned, is with the technique of active imaginative training.

In effect, there are two phases to the combination. In the first phase planning is done with the patient; in the second, visualization of desired qualities and situations. The visualization may bring up certain resistances; and even without resistances it may be useful to have the patient visualize himself in certain situations, such as being with his parents or children or his mate, and also at work; this may bring out certain negative reactions—which could be partly dealt with by the technique of imaginative training before going back again to the previous stage of the model of the desired goal. This means that you do not necessarily separate the techniques of the stages; e.g., "Now I am going to concentrate on planning, now I am going to concentrate on the visualization of situations which may bring forth negative—but also positive—reactions." It is a kind of fluid combination of all stages so that from the different points the patient progresses. He progresses in awareness and clarification of a realizable goal, and he also progresses in the awareness of those aspects in himself of which he was afraid, so that he can accept them and incorporate them better because the constructive aspect is also being reinforced.

In other words this is one of the specific procedures of psychosynthesis: what could be called a moving back and forth between the various stages and in the use of various techniques. It is a fractioned psychoanalysis or a partial use of a technique and then a passing to others; then a coming back again to a further stage in the use of that technique. This working in a fluid way might seem at first to be lacking order, but is in fact obedient to a higher order of organic development.

Another procedure in psychosynthesis is the use of not only verbal material but also imaginative visualized material, and any therapist who has really had experience in this process begins to realize that he is dealing with a very powerful technique, which

because of its power represents both opportunities and dangers, and for which he must be fully prepared. Only those therapists who, if not at peace, are at least fairly comfortable with their own unconscious material (which sometimes is of a primitive kind) can be at home with similar processes in the patient, without imposing a rigid structure on what goes on.

This brings up again a point which cannot be emphasized enough: the thorough psychosynthetic preparation of the therapist himself. As to the points of danger, we recall those—well described by Jung—of the invasion of the consciousness by strong images from the unconscious, especially the deeper levels which he calls the "Collective Unconscious," and which contain the archetypal images.

TECHNIQUE OF SYMBOL UTILIZATION

Purpose

The purpose of this technique is to utilize the enormous and by far not yet realized potency of symbols in the dynamics of the psychological life. Symbols are constantly being used by everyone but generally in an unconscious way and often in unconstructive and even harmful ways. Therefore one of the urgent needs of therapy—and of education—is the realization of the nature and power of symbols, the study of the many classes and kinds of symbols, and their systematic utilization for therapeutic, educational, and self-realization purposes.

Apart from and in addition to this general, one could almost say universal, purpose of symbols in human life, there is a specific purpose for their use in psychosynthesis, because there are symbols which have a specific psychosynthetic integrating value and therefore directly serve the purpose of bringing about psychosynthesis, both in the individual and in groups.

Rationale

The rationale of the use of symbols is based on their nature and on their function, or rather functions. Let us first consider symbols from the psychodynamic standpoint.

Their primitive and basic dynamic function is that of being accumulators, in the electrical sense, as containers and preservers

crowd—or in the presence of a hostile person—or confronted by a difficult problem—or obliged to do many things rapidly—or in danger—and *see* and *feel* yourself calm and serene.

5. Pledge yourself to remain serene throughout the day whatever happens; to be a living example of serenity; to radiate serenity.

* * * *

Note: This same pattern can be used for the purpose of evoking and developing any other psychological quality such as Courage, Decision, Patience, etc.

CHAPTER VI

Technique of Imaginative Evocation of Interpersonal Relationships

Purpose

The purpose of this technique is to enable the patient to achieve the right inner attitude towards other people and to successfully perform intended actions involving others. This is achieved in two stages: the first is to eliminate the hindrances, unconscious or conscious, blocking the free attainment of that right inner attitude. This includes not only the development of desirable attitudes towards other people but also the development of desirable attitudes towards oneself. The second stage is a gradual training in developing facility in outer interpersonal relations.

Rationale

The rationale of the first stage, of the elimination of obstacles, is the same as that on which the technique of catharsis is based, i.e., the elimination through the outward expression of emotional charges which exist either in the unconscious and/or in the conscious. This may involve something more than simple catharsis, namely an understanding of the negative emotions, and so on.

The rationale of the second stage is that of the creative effects of imaginative visualization and the evocation of positive images. These create the "model," and arouse the impulse to successful action.

Procedure

The procedure is best explained by an actual description of the technique in action, applied to one of the simpler types of cases, i.e., of preparing for and making possible the performance of an action which appears difficult and arouses fear and anxiety.

The first step is to ask the patient to give a verbal description—as accurate and detailed as possible—of the action to be performed. Let us take the instance of a scholastic oral examination; the student is asked to describe the building and room where the examination will take place, and to give as many details as possible about the examining professor, the subject of examination, the possible questions which may be asked, etc.

After the patient has given that description, he is asked to lie down in a comfortable position on the couch. Then with the help of the therapist an exercise of relaxation is given (such as that on p. 223). When a degree of relaxation has been achieved the therapist repeats the description of the examination fully and realistically, coupled with the instruction to the patient to vividly imagine the scene as if he were actually participating in it. The patient is further told to permit his reactions to emerge freely without any inhibition, i.e., all the reactions evoked by the imaginative living through the examination, such as the subjective emotional states and their accompanying psychosomatic reactions, such as trembling, perspiring, etc. This acts as a catharsis.

The procedure then has to be repeated in further sessions. Often in the second session the reactions are just as intense as in the first, but with successive repetitions they become less and less intense until they spontaneously disappear or become very weak. This completes the first stage of the technique which may be called that of "imaginative desensitization" and the time has come when the patient can be encouraged to prepare to actually face the previously feared ordeal.

This second stage could be called "the visualization of the desired attitude and successful performance." However, this often

happens by itself, for in the final repetitions of the first stage the patient may spontaneously feel that he has already gained the right attitude, i.e., in imagination he can now take the examination calmly, confidently, and without any emotional reaction. When this comes spontaneously, it is proof that the negative emotions have really been eliminated.

This procedure, with its two stages, can be modified or adapted to other situations, such as interpersonal relationships with parents or with superiors, which may arouse if not fear, at least anger and aggressiveness.

It is particularly useful to have the patient visualize himself in all sorts of interpersonal relationships with parents, persons of the opposite sex, etc. In these cases it is advisable to have the patient lie on the couch in order to allow the free emergence of all kinds of feeling reactions. And only after this has been repeatedly experienced in a succession of sessions do we ask the patient to adopt a sitting position, and to begin more specifically to visualize the desired attitude and relationships.

For instance: we have in mind a woman patient who had difficulty in her relationships with her parents. We prompted her to recall and re-live past scenes with them, and for the first time in her adult life she fully experienced the rage and hatred that she had felt at the time of those long past incidents. Only after these had been repeatedly experienced in imagination did we move to the next stage of visualizing the possible "love" attitude of this woman towards her parents.

There are many individuals, seemingly normal and psychologically healthy, who yet are uneasy in interpersonal relationships, and because of this put distance between themselves and other people. Again, before they can be asked to visualize themselves in close intimate relationships of warmth and affection with other human beings it is necessary to have them re-experience the fears and other hostile feelings—often unconscious—which are the basis of the difficulties in their personal relationships.

Indications and Applications

These are clear from what has been mentioned in the preceding paragraphs. They are very wide; but to summarize, they cover three main classes of situations:

1. The performing of difficult or feared actions.
2. The realization of harmonious interpersonal relationships, and other more complex kinds of social behavior.
3. The development of awareness of one's attitudes towards oneself and their modification into more constructive and realistic ones.

The effects of this technique have been very gratifying. The subjects often acquire a new and joyous sense of freedom, of independence, of mastery over situations, tasks, and relationships.

Limitations and Contra-Indications

There are really no definite and serious contra-indications, provided the therapist takes care, in the stage of the free emergence of reactions from the unconscious, that the conscious personality of the patient is not submerged by an uncontrolled inrush of other unconscious repressed contents released through the opening made. Such unconscious contents have their origin in the deeper layers of the unconscious, and even in the so-called "collective" unconscious. As Jung has pointed out, this can be a real danger and many of us have had occasion to confirm this in our therapeutic experience.

The best protection against this danger, in certain cases of borderline psychosis, lies in using this technique only after a certain measure of consolidation of the conscious personality has been achieved, and only after the patient has gained an awareness of the laws and mechanisms of the psychological life.

It is also possible—as has been described by Desoille in his technique of the "Rêve Eveillé"—for the therapist to suggest certain protective images; and also to present less threatening images at the point where he feels that the patient may become overwhelmed by unconscious material.

Combination with Other Techniques

This technique can be usefully combined or alternated with all the psychoanalytical procedures; for instance, with catharsis. It is also closely allied with, and in a sense preparatory to, the imaginative evocation of the ideal model.

COMMENTS ON THE TECHNIQUE OF HENRI BARUK FOR THE RELATIONSHIP BETWEEN THERAPIST AND PATIENT

In his *Traité de Psychiatrie* (Paris: Masson, 1959, Vol. II) Professor Henri Baruk describes his main technique in the treatment of psychiatric and psychoneurotic patients. He emphasizes a group of techniques which concern the attitude of the therapist, his preparation and his relationship with his patients.

The first and more general task is that the therapist must realize the global influence that his personality—or rather that he as a human being—exercises on the patient. This happens spontaneously, naturally and inevitably, but he then proceeds from this spontaneous and unconscious influence to an increasingly conscious and direct one. Further, he eliminates those aspects of the influence which might be harmful or create an obstacle in the treatment, emphasizing—or even developing, if absent—certain possible influences which are directly constructive and helpful in the treatment.

This point has also been dealt with by other therapists, for instance: Alfonse Maeder in *La Personne du Médecin-un agent psychotherapeutique* (Neuchatel, Delachaux & Niestlé, 1953), and the German psychotherapist, Tochtermann in *Der Arzt als Arznei* (Dusti Verlag, Remscheidt, 1955).

Baruk's specific technique is based on his fundamental conception that in every patient, including serious psychiatric cases, behind the pathological facade of symptoms and disorders there is an aspect which remains unaffected, and the characteristic of which is moral conscience. This has been dealt with in several of his books and he has given satisfactory proof of the reality of his conception. (Henri Baruk: *Psychiatrie Morale Expérimentale, Individuelle et Sociale,* Paris, Presses Universitaires, Second Edition, 1950). Baruk, accordingly, in his therapy directs himself to the healthy aspects of the patient, particularly to his moral conscience. He identifies his procedure with a word he himself created: "CHITAMNIE," which means in his interpretation "the method of trust"; i.e., trusting the patient.